nehta

Core Information Components

Specialist Letter

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Final

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Document Information

Change history

Version	Date	Contributor	Comments
0.1	2010-02	Rob Eastwood	First draft.
0.2	2010-11	Rob Eastwood	Updates following workshops and questionnaire.
0.2.1	2011-03	Rob Eastwood	Minor updates.
0.2.2	2011-03	Rob Eastwood	Minor updates.
0.2.3	2011-03	Rob Eastwood	Minor corrections.
1.0	2011-03-25	Rob Eastwood	Release for comment.
1.0.1	2011-05-04	Rob Eastwood	Added reference to DCM in section 2.1
1.0.2	2011-06-17	Rob Eastwood	Changes following external feedback
1.0.3	2011-07-06	Rob Eastwood	Further changes following external feedback
1.0.4	2011-12-12	Rob Eastwood	Preface: removed sentence with reference to "*the Business Requirements Specification and Solution Design*".

Document authorisation

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Preface

Document Purpose

This document presents the core information components of the Specialist Letter 1.0 package release, which are recommended for use when sending electronic responses from specialists back to the referring general practitioners within Australia.

The information components are a logical set of data items for exchange and are therefore independent of any particular platform, technology, exchange format or presentation format.

The Specialist Letter package describes the specifications and guidelines to be adopted by implementers when developing interoperable referral solutions within the Australian healthcare community. Detailed, supporting documentation will soon become available providing specific implementation guidance.

Updates to this document will be published as additional package components are developed, with feedback from the sector.

Intended Audience

This document is intended for all interested stakeholders including:

- Clinicians, such as general practitioners and specialists
- Early adopter hospitals and health departments in the process of planning, implementing or upgrading eReferral systems
- Software vendors developing eReferral system products
- Early adopter general practitioner and specialist desktop software vendors
- Senior managers and policy makers, clinical experts, health information managers, IT operations and support teams, system integrators
- Stakeholders associated with the development and use of upcoming e-health initiatives relating to 'continuity of care'
- Both technical and non-technical readers.

Document Map

The following diagram represents the relationship between this document and others within the specialist letter package.

Figure 1   Package document map

The Core Information Components document defines the minimum set of data groups and elements that are recommended for implementation in any system that creates and transfers specialist letter information within Australia. The Solution Design defines current, interim and future solution states supported by the Business Requirements Specification.

Document Status

Final.

Definitions, Acronyms and Abbreviations

For a list of abbreviations, acronyms and abbreviations, see the Definitions section at the end of the document, on page 52.

References and Related Documents

For a list of all referenced documents, see the References section at the end of the document, on page 53.

1   Introduction

1.1   Overview

This document presents the Core Information Components for a specialists' clinical response to a general practice (GP) referrer, as recommended for use in Australian referral systems. Within this package this clinical response is known as the electronic specialist letter (SL),

The Core Information Components are the minimum set of data items that are recommended for implementation in any system that creates and transfers information from specialists to GP referrers in Australia, to support the delivery of quality collaborative care. The inclusion of data in this minimum set is determined by two criteria:

1.   The clinical relevancy of the data

2.   The potential for the data to ensure clinical safety in a collaborative care environment.

As these specifications define the Core Information Components for exchange, it is anticipated that some specialist letter templates will contain additional types of data to satisfy specific local or specialty healthcare requirements. It is expected that national extensions to the Core Information Components will be defined to support particular specialty areas.

For business-related discussion, please see the Business Requirements Specification document, also part of the Specialist Letter Release 1.0 package [SL-BRS2010].

1.2   Scope

1.2.1   Scope Inclusions

The specialist letter work is essentially an extension of the Electronic Referrals Release 1.1 [ERR2011] published in Feb 2011 and as such, it shares scope, as follows:

- The scope of the Electronic Referrals Release 1.0 package includes electronic referral processes, between general practitioners and specialists

- The specific scope of the specialist letter work is the sum of clinical responses made by a specialist after receiving a general practitioner's (GP) referral.

1.2.2   Scope Exclusions

The following workflow aspects are specifically excluded from this package extension:

- The means by which a referral to a specialist is declined by that specialist, or more information is sought from the referring GP

- Details regarding appointment scheduling

- The process which identifies when a patient fails to attend a scheduled specialist appointment.

It is recognised that these matters are important aspects of the workflow and will be dealt with in due course by other means.

1.3 Purpose

The purpose of the Specialist Letter Core Information Components is to define the information requirements for a nationally-agreed response to a referral for exchange between healthcare providers in Australia, independent of exchange or presentation formats.

It is anticipated that these Core Information Components will:

- Promote a common understanding of the core information components required for constructing and consumption of specialist letters to GPs, other recipients, implementers and jurisdictions

- Provide a common framework for development and use of semantically interoperable information components to be exchanged between applications, providers, jurisdictions

- Provide a common framework for defining queries using these core information components at logical levels, which may be adopted for implementations in local, jurisdictional or national Electronic Health Record environments

- Provide a common framework upon which to define nationally-agreed, specialty-specific information components (e.g. for Allied Health)

- Provide a common framework for nationally-defined mappings to specific exchange formats

- Provide a framework (along with other documents and structures) suitable for the development of national terminology sets that associate specific data items with valid values. These values will be derived from nationally endorsed terminologies maintained and distributed on behalf of Australia by NEHTA's National Clinical Terminology and Information Service (NCTIS). The current terminology sources that will provide this content are LOINC for defined areas of Pathology content, SNOMED CT-AU for all other clinical content and Australian Medicines Terminology (AMT) for medicinal products. Administrative content will be derived either from SNOMED CT-AU or specifically defined external codesets.

1.4 Exchange and Presentation Formats

The information presented here is defined at the logical level, and is therefore independent of specific exchange or presentation formats (e.g. HL7 v2 or HL7 Clinical Document Architecture [CDA]).

Consequently, the Core Information Components will be mapped to HL7 CDA exchange format and will be defined and published following the endorsement of the Core Information Components.

Similarly, the requirement that a particular piece of data be exchanged in a specialist letter does not imply a requirement on the user interface. Some data elements (e.g. 'Document Originating System Identifier') are intended purely for purposes of internal processes within the receiving system. Similarly, other data elements (e.g. 'Date of Birth') have a number of different presentation options available (e.g. 'Birth Day' + 'Year of Birth' etc), which are not considered here. In addition to this, the names given to data components and data items are in many cases not appropriate to be used as field labels on a user interface.

Implementations which modify the data item names in the 'Item' column of the following section to accommodate local practices (e.g. 'Person name' represented as 'Patient Name') may still conform to this specification, but only if the meaning of the variables listed in the other columns are not modified.

Please also note that the order in which the data items are listed in this document is not indicative of the order in which this data should be exchanged or presented to the user.

1.5   Adding Data

It is expected that the specialist will use their clinical judgement to manually enter some of the data into the specialist letter core information components. However, it is envisaged that Clinical Information Systems operating at the source should be capable, wherever possible, of transferring relevant data into many of the core information components. This will minimise data entry and may reduce the issues of recording data redundantly in multiple data stores. It is expected that where feeder systems are used, the author's discretion is exercised in only allowing information relevant to the ongoing care of the patient to be included in the letter, and that the author's due diligence is applied to ensure that the information included from feeder system is current and accurate.

Note that some of the data elements included in this specification are required for ALL specialist letters whereas others need only be completed where appropriate. That is, a conformant Specialist Letter implementation must be capable of collecting and transferring/receiving all Core Information Components (CIC) elements.

However:

- Not all data elements require a value in each and every Specialist Letter (e.g. items that are categorised with '0..1' or '0..Many'). For example, "Diagnostic Investigations (0..Many)" some clinical circumstances do not require that a letter contain diagnostic investigations.

- Not all data elements are required to be displayed to users, and their labels may be different from those used in the 'Item' column of the Definition table in the following sections.

2 Core Components

2.1 Overview

The information components of the specialist letter core information components (as defined in the following sections) define the minimum set of data that is recommended for best practice implementation in a system that creates and exchanges referral information within Australia.

The current Core Information Components are:

Component
Patient
Specialist
Referring GP
Usual GP
Document Recipients
Response Details
Recommendations
Medicine List
Allergies/Adverse Reactions
Diagnostic Investigations
Attachments
Document Control

Each component is firstly described in terms of what the requirements are, providing a rationale.

A small number of indicative samples for usage are included to provide additional clarity but are not intended to be a prescription for display. Note also that all content in the samples is completely fictitious.

This is followed with a representation of the proposed data model for each.

2.2 Data Model Description

The proposed data model for each of the components is defined below, using the following columns:

- *Component:* A high level section or group of data elements

- *Item:* An individual data element or data group. A data item may be a single unit of data (e.g. "Date of Birth"), or a set of data that has a standard structure (e.g. "Address")

- *Type:* The type of data associated with the component or data item. Note that this may be a simple data type (e.g. text, date) requiring a single field, or a predefined structure requiring a group of fields.

- *Number of Values Allowed:* The number of times that the given component/item may be included in a specialist letter. For items, this is the number of times that the given item may be included, each time the component to which it belongs is included. The number of values may be either:

- – 0..1 (Zero or One):   At most one data value
- – 1 (One)[1]   Exactly one data value
- – 0..Many (Zero to Many) Any number of data values
- – 1..Many (One to Many) At least one data value.

- *Notes:* Additional comments that clarify, explain or constrain the given data.

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[1] This is generally expressed in technical documentation as "1..1". It has been simplified in the following tables to "1"

2.3   Component: Patient

Description: Identifies the person about whom the clinical interaction has been captured and interchanged, that led to the response to the referral; that is, the subject of the specialist's letter.

2.3.1   Requirements

For a electronic document to be correctly regarded as a compliant specialist letter, it must agree to a list of requirements designed to pick out key information, as follows.

Data item	Requirement statement	Rationale
Component	Each specialist letter shall always contain information about the patient and shall always contain the following mandatory items.	A specialist's letter is only created pertaining to a patient and one cannot exist without that patient.
Patient Name	The name of the patient shall be recorded in every SL.	Clinical safety. Patient identification.
	The recording of a patient name shall be consistent with Australian Standards of naming.	Allows interoperability. Eliminates ambiguity.
Person Identifier	Every SL shall contain the patient's Individual Healthcare Identifier (IHI).	Allows interoperability. Eliminates ambiguity. Clinical safety.
	A SL shall be allowed to contain multiple patient identifiers.	Optionally the patient's local identifier to support transition to the use of national identifiers.
Date of Birth	Every SL shall contain the patient's date of birth.	Clinical safety. Patient identification.
	An approximation for the date of birth shall be allowed (such as only the year, or the month and year) only when the exact date is not known. That is, when the exact date is known, the full date shall be provided.	The patient's exact date of birth may not be known.
	When the date of birth is an approximation, an indication of such shall be included.	Eliminates ambiguity
Sex	The patient's sex shall be recorded in every SL.	Clinical safety. Patient identification.
	The patient's sex shall be recorded using (and be restricted to) the Australian Institute of Health and Welfare Person—Sex Data Element Concept values.	Allows interoperability. Eliminates ambiguity.
Address	The patient's address shall be recorded in every SL.	Patient identification.
	The recording of patient address shall be consistent with Australian Standards of address recording.	Allows interoperability. Eliminates ambiguity.
	There shall be provision for recording the patient's	Patients may not always have a fixed place of abode nor may the

Data item	Requirement statement	Rationale
	address as not known or that they have no fixed address.	address be known in all cases.
Communication Details	The SL shall have the provision to record contact details for the patient.	Allows ready access to contact the patient, should the recipient not have those details at hand.
	A value for patient's communication detail shall only be included when it is deemed by the specialist to relevant/appropriate to do so (i.e. optional to include a value).	A patient's contact may not be available or appropriate to include.
	A SL shall be allowed to contain multiple patient communication details.	This allows recording of (for example) a home landline, a work mobile and an email address.
	The contact details record shall include provision for the medium (e.g. telephone, email), usage (e.g. home, work) as well as the actual details.	Allows interoperability. Eliminates ambiguity.

2.3.2   Samples & usage

1. The patient has only provided the least amount of information - that is, one address and no contact details.

PATIENT		
Name	Mr William SMITH	
IHI	8003600200002222	
Date of Birth	01/01/1946 (63 years)[2]	**DOB approx?** No
Sex	Male	
Address	Residence: 20 Chapel Street, Lilydale, VIC, 3002	
Contact		

2. Later, the same patient provides more demographic information, but they do not recall the exact date of their birth.

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[2] The age of the patient would be a calculated value rather than being a separate data item.

PATIENT		
Name	Mr William SMITH	
IHI	8003600200002222	
Date of Birth	1946 (63 years)	**DOB approx?** Yes
Sex	Male	
Address	Residence: 20 Chapel Street, Lilydale, VIC, 3002 Postal: PO Box 123, Lilydale, VIC, 3002	
Contact	Home Phone: 03 3988 7156 Mobile: 0411 378 942 Email: mwsmith@internetprovider.com.au	

2.3.3 Proposed Data model

Data items	DataType	Number of Values Allowed	Notes
Person Name	Person Name data group	1	The patient's name, structured using a predefined type, consistent with Australian standards of naming (e.g. family name and first name etc), as detailed in NEHTA's Participation Data Specification [fd].
Person Identifier	Unique Identifier	1..Many	The unique identifier of the patient. This must include the patient's Individual Healthcare Identifier (IHI) and optionally the patient's local identifier.
Date of Birth	DateTime	1	The patient's date of birth. Where the exact date of birth is not known, this may be an approximation, which includes only the year, or the month and year.
Date of Birth accuracy Indicator	Boolean	0..1	The level of certainty or estimation of an individual's date of birth.
Sex	Coded Text	1	The sex of the patient. Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.[3]
Address	Address data group	1..Many	The address of the patient, recorded in a structured format, consistent with Australian standards of address recording, as detailed in NEHTA's Participation Data Specification [PDS2011]. Where the patient's address is not known, the address line can be populated with text entry of "patient has no known address." This may include "No fixed address" if appropriate.
Communication Details	Electronic Communication Details data group	0..Many	The patient's preferred means of contact should be included to facilitate clinical follow-up. Each Contact Details data item includes the medium (e.g. telephone), usage (e.g. home) and details. A value is not always required because it may not be available or appropriate.

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[3] Source of definition: Australian Institute of Health and Welfare; Person—sex Data Element Concept (METeOR identifier: 269716) http://meteor.aihw.gov.au/content/index.phtml/itemId/269716 (accessed 1 October 2010)

2.4 Component: Specialist

Description: The specialist to whom the patient has been referred and who is the author of the Specialist Letter.

2.4.1 Requirements

Data item	Requirement statement	Rationale
Component	Each SL shall always contain information about the specialist who has written the letter and shall always contain the following mandatory items.	It is important for all recipients to clearly know from whom the letter originated.
Person Name	The name of the specialist shall be recorded in every SL.	It is important for all recipients to clearly know from whom the letter originated.
	The recording of specialist's name shall be consistent with Australian Standards of naming.	Allows interoperability. Eliminates ambiguity.
	Only one specialist name record shall be allowed.	Reduce complexity.
Person Identifier	Every SL shall contain the Healthcare Provider Identifier of the specialist (HPI-I).	Allows interoperability. Eliminates ambiguity. Clinical safety.
	An SL shall be allowed to contain multiple personal identifiers of the specialist, as required.	Such as provider or prescriber numbers.
Specialty	Every SL shall include particular speciality of the specialist.	It is important for all recipients to clearly know from whom the letter originated as well as specifically to which specialty they belong.
	An SL shall be allowed to contain multiple specialities for the given specialist.	Some specialists have qualifications in multiple specialities and in the course of consulting the patient and preparing the specialist letter, they may be functioning in more than one capacity.
Organisation Name	The SL shall record the organisation to which the specialist is affiliated, in the context of a given referral.	Whilst a specialist may practice at multiple organisations, a given patient consultation following a referral would occur at one of those organisations.
Organisation Identifier	The SL shall record the unique organisation identifier organisation to which the specialist is affiliated - the Healthcare Provider Identifier of the organisation (HPI-O)	Allows interoperability. Eliminates ambiguity.
Address	The specialist's practicing address shall be recorded in every SL.	Whilst a specialist may practice at multiple addresses, a given patient consultation following a referral would occur at one of those. Inclusion of the address assists follow-up should that be required.
	The recording of the specialist's address shall be consistent with Australian Standards of address	Allows interoperability. Eliminates ambiguity.

Data item	Requirement statement	Rationale
	recording.	
	A SL shall be allowed to contain multiple addresses for the given specialist.	Caters for the street address as well as the postal address.
Communication Details	At least one contact detail for the specialist shall be recorded in every SL.	Inclusion of the Communication Details assists follow-up should that be required.
	A SL shall be allowed to contain multiple specialist communication details.	This allows relevant telephone numbers (i.e. daytime, after hours, mobile, etc.) and email addresses to be recorded for future reference.
	The contact details record shall include provision for the medium (e.g. telephone, email), usage (e.g. after hours) as well as the actual details.	Allows interoperability. Eliminates ambiguity.

2.4.2   Samples & usage[4]

1. The specialist works within the organisation 'Canberra Cardiovascular Group'.

SPECIALIST	
Name	Dr Ethan JONES [HPI-I: 8003610200002388]
Specialty	Cardiologist
Organisation	Canberra Cardiovascular Group [HPI-O: 8003620000000222]
Address	40 General Street, Canberra, ACT 2600
Contact	Email: admin@ccg.com.au Phone: 02 3998 9995

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[4] Health identifier numbers are predominantly for system to system usage and as such they may not necessarily be displayed to end users. The HI numbers are only displayed here to provide additional clarity for these specifications and as such, the reader should not consider this a display requirement.

2. The specialist is both a neurologist and an ophthalmologist.

SPECIALIST	
Name	Mr Harry JONES [HPI-I: 8003610200002377]
Specialty	Neurology; Ophthalmology
Organisation	Brisbane Specialist Services Group [HPI-O: 8003620000000226]
Address	15 Michael Ave, Brisbane, QLD 4100
Contact	Email: hjones@internetprovider.com.au Phone: 0411 222 222

2.4.3 Proposed Data model

Data items	DataType	Number of Values Allowed	Notes
Person Name	Person Name data group	1	The name of the specialist, structured using a predefined type consistent with Australian standards of naming (e.g. family name and first name etc), as detailed in NEHTA's Participation Data Specification [PDS2011].
Person Identifier	Unique Identifier	1..Many	The unique individual identifier of the specialist. This must include the Healthcare Provider Identifier of the specialist (HPI-I) and optionally other identifiers (such as provider or prescriber numbers).
Specialty	Codeable Text	1..Many	The specialist's clinical specialty (or specialities). For example; 'Orthopaedic Surgeon'. In some circumstances, a specialist may belong to more than 1 specialty (e.g. Neurologist and Ophthalmologist).
Organisation Name	Organisation Name	1	The name of the healthcare provider organisation at which the specialist practices.
Organisation Identifier	Unique Identifier	1	The unique Healthcare Provider Identifier of the organisation (HPI-O) to which the patient has been referred.
Address	Address data group	1..Many	The address of the specialist, recorded in a structured format consistent with Australian standards of address recording, as detailed in NEHTA's Participation Data Specification [PDS2011].
Communication Details	Electronic Communication Details data group	1..Many	The contact details for the specialist. The preferred means of contact should be included and should include at least one method of communication. Each Contact Details includes the medium (e.g. telephone), usage (e.g. work) and details.

2.5   Component: Referring GP

Description: The medical practitioner who has referred the patient to the specialist.

2.5.1   Requirements

Data item	Requirement statement	Rationale
Component	Each SL shall always contain information about the GP who originally made the referral to the specialist and shall always contain the following items.	As a specialist letter is a clinical response back to the referring GP, it is important to clearly identify to whom the letter is addressed.
Person Name	The name of the GP who has referred the patient shall be recorded in every SL.	Clearly identify to whom the letter is addressed.
	The recording of the referring GP's name shall be consistent with Australian Standards of naming.	Allows interoperability. Eliminates ambiguity.
	Only 1 name record shall be allowed for the referring GP.	Avoids unnecessary complexity.
Person Identifier	Every SL shall contain the Healthcare Provider Identifier of the referring GP (HPI-I).	Allows interoperability. Eliminates ambiguity. Clinical safety
	A SL shall have the provision to contain multiple personal identifiers of the referring GP, as required.	Such as provider or prescriber numbers.
Organisation Name	The SL shall record the organisation/practice to which the referring GP is affiliated.	Whilst the Referring GP may practice at multiple organisations, a given patient referral would have occurred at one of those organisations.
Organisation Identifier	The SL shall have record the unique organisation identifier to which the referring GP is affiliated - the Healthcare Provider Identifier of the organisation (HPI-O).	Whilst the Referring GP may practice at multiple organisations, a given patient referral would have occurred at one of those organisations.
Address	The referring GP's practicing address shall be recorded in every SL.	Whilst the Referring GP may practice at multiple organisations, a given patient referral would have occurred at one of those organisations.
	The recording of the referring GP's address shall be consistent with Australian Standards of address recording.	Allows interoperability. Eliminates ambiguity.
	A SL shall be allowed to contain multiple addresses for the given referring GP.	Caters for the street address as well as the postal address.
Communication Details	At least one contact detail for the referring GP shall be recorded in every SL.	Other CC recipients of a specialist letter may need to contact the referring GP.
	A SL shall be allowed to contain multiple referring GP	This allows relevant telephone numbers (i.e. daytime, after hours,

Data item	Requirement statement	Rationale
	communication details.	mobile, etc.) and email addresses to be recorded for future reference.
	The contact details record shall include provision for the medium (e.g. telephone, email), usage (e.g. after hours) as well as the actual details.	Allows interoperability. Eliminates ambiguity.

2.5.2   Samples & usage[5]

1.   The referring GP works for a practice 'Canberra Medical Centre'.

REFERRING GP	
Name	Dr Jeremy BROWN [HPI-I: 8003610200002344]
Organisation	Canberra Medical Centre [HPI-O: 8003620000000233]
Address	2 Scenic Street, Canberra, ACT 2600
Contact	Email: admin@cmc.com.au Phone: 02 3998 8888

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[5] Health identifier numbers are predominantly for system to system usage and as such they may not necessarily be displayed to end users. The HI numbers are only displayed here to provide additional clarity for these specifications and as such, the reader should not consider this a display requirement.

2.5.3   Proposed Data model

Data items	DataType	Number of Values Allowed	Notes
Person Name	Person Name data group	1	The name of the referring GP, structured using a predefined type consistent with Australian standards of naming (e.g. family name and first name etc), as detailed in NEHTA's Participation Data Specification [PDS2011].
Person Identifier	Unique Identifier	1..Many	The unique individual identifier of the referring GP. This must include the Healthcare Provider Identifier of the referring GP (HPI-I) and optionally other identifiers (such as provider or prescriber numbers).
Organisation Name	Organisation Name	1	The name of the healthcare provider organisation at which the referring GP practices.
Organisation Identifier	Unique Identifier	1	The unique Healthcare Provider Identifier (HPI-O) of the referring GP's practice.
Address	Address data group	1..Many	The address of the referring GP, recorded in a structured format consistent with Australian standards of address recording, as detailed in NEHTA's Participation Data Specification [PDS2011].
Communication Details	Electronic Communication Details data group	1..Many	The contact details for the referring GP. The preferred means of contact should be included and should include at least one method of communication. Each Contact Details includes the medium (e.g. telephone), usage (e.g. work) and details.

2.6 Component: Usual GP

Description: The medical practitioner nominated by the patient as his/her "usual GP". The Australian Medical Association (AMA) Position Statement on Referrals within the Profession[6] states that:

The AMA believes the role of the General Practitioner to be central to the patient's management. As the first point of contact and the primary care provider, the general practitioner is responsible for coordinating the ongoing health care of the patient, in consultation with consultant colleagues and allied health professionals, whether in public or private practice.

In many cases, the referring GP will be the patient's usual GP, but that may not always be the case. For example, a patient may be unable to see their usual GP and sees another GP at that practice, or a locum / after-hours GP at another clinic.

2.6.1 Requirements

Data item	Requirement statement	Rationale
Component	There shall be the provision to record details about a patient's usual GP, with details structured as described below.	Most patients will have a usual GP who act as the central coordinator of their care. As such, they should be kept informed about events should they not have been directly involved in them (e.g. the referral was made by an after-hours clinic).
	Information about the GP who has been nominated by the patient as his/her usual GP shall only be included when that information is available or appropriate to include.	Whilst it may be best-practice for all patients to have a nominated usual GP, in some cases, a patient may not actually have one. Alternatively, a patient may elect to see a different GP for a sensitive condition, for which they do not want their usual GP to become aware of. They then choose not to identify their usual GP to either the referring GP or the specialist.
Person Name	The SL shall have the provision to record the name of the usual GP.	Clearly identifies the GP.
	A value for Person Name shall be included whenever the usual GP is an individual. A value for Person Name shall not be included when the usual GP is not an individual.	A patient may regularly visit a GP practice but not have specifically nominated one of the individual GPs to be their 'usual GP'. The patient has chosen to be managed by any GP at that particular practice.
	When recorded, the name of the usual GP shall be consistent with Australian Standards of naming.	Allows interoperability. Eliminates ambiguity.
	When recorded, only 1 name record shall be allowed for the referring GP.	Avoids unnecessary complexity.
	When the usual GP nominated is an individual, their	Clearly identifies the name of the GP.

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[6] AMA Referrals within the Profession – 2007 (point 1.1) http://ama.com.au/node/2804 (accessed Tuesday, 26 October 2010)

Data item	Requirement statement	Rationale
	name shall be provided.	
Person Identifier	The SL shall have the provision to record the Healthcare Provider Identifier of the usual GP (HPI-I).	Allows interoperability. Eliminates ambiguity. Clinical safety.
	A value for Healthcare Provider Identifier (HPI-I) for a usual GP shall be included whenever the usual GP is an individual. A value for Healthcare Provider Identifier (HPI-I) for a usual GP shall not be included whenever the usual GP is not an individual.	A patient may elect to have a particular GP as their usual GP. A patient may regularly visit a GP practice but not have one of the individual GPs there nominated as their 'usual GP'. The patient has chosen to be managed by any GP at that particular practice, in which case the usual GP is the GP practice organisation.
	A SL shall be allowed to contain multiple personal identifiers of the usual GP, as required.	Such as provider or prescriber numbers.
Organisation Name	The SL shall record the name of the organisation/practice to which the usual GP is affiliated or the organisation/practice which the patient has nominated as their usual GP practice.	Whilst the usual GP may practice at multiple organisations, a given patient referral would have occurred at one of those organisations. A patient may only nominate a usual GP practice (as an organisation) rather than a specific GP at that practice.
Organisation Identifier	The SL shall record the the Healthcare Provider Identifier of the organisation (HPI-O) to which the usual GP is affiliated, or the organisation identifier of the practice which the patient has nominated as their usual GP practice.	Whilst the usual GP may practice at multiple organisations, a given patient referral would have occurred at one of those organisations. A patient may only nominate a usual GP practice (as an organisation) rather than a specific GP at that practice.
Address	The usual GP's practicing address shall be recorded in every SL.	Whilst the usual GP may practice at multiple organisations, a given patient referral would have occurred at one of those organisations.
	The recording of the usual GP's address shall be consistent with Australian Standards of address recording.	Allows interoperability. Eliminates ambiguity.
	A SL shall be allowed to contain multiple addresses for the usual GP.	Caters for the street address as well as the postal address.
Communication Details	At least one contact detail for the usual GP shall be recorded in every SL.	Other CC recipients of a specialist letter may need to contact the usual GP.
	A SL shall be allowed to contain multiple usual GP communication details.	This allows relevant telephone numbers (i.e. daytime, after hours, mobile, etc.) and email addresses to be recorded for future reference.
	The contact details record shall include provision for the medium (e.g. telephone, email), usage (e.g. after hours) as well as the actual details.	Allows interoperability. Eliminates ambiguity.

2.6.2   Samples & usage[7]

1.   Patient A, is referred by her usual GP to a specialist. In this case the Referring GP is that same as the Usual GP and the identical information may be replicated by the software into both sections.

USUAL GP	
Name	Dr Jeremy BROWN [HPI-I: 8003610200002344]
Organisation	Canberra Medical Centre [HPI-O: 8003620000000233]
Address	2 Scenic Street, Canberra, ACT 2600
Contact	Email: admin@cmc.com.au Phone: 02 3998 8888

REFERRING GP	
Name	Dr Jeremy BROWN [HPI-I: 8003610200002344]
Organisation	Canberra Medical Centre [HPI-O: 8003620000000233]
Address	2 Scenic Street, Canberra, ACT 2600
Contact	Email: admin@cmc.com.au Phone: 02 3998 8888

However, software logic for the display of this information may make sense: *when Referring GP = Usual GP*, then display as follows:

USUAL and REFERRING GP	
Name	Dr Jeremy BROWN [HPI-I: 8003610200002344]
Organisation	Canberra Medical Centre [HPI-O: 8003620000000233]
Address	2 Scenic Street, Canberra, ACT 2600
Contact	Email: admin@cmc.com.au Phone: 02 3998 8888

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[7] Health identifier numbers are predominantly for system to system usage and as such they may not necessarily be displayed to end users. The HI numbers are only displayed here to provide additional clarity for these specifications and as such, the reader should not consider this a display requirement.

2. Alternatively, whenever the Referring GP differs from the Usual GP, both sections must be displayed with the following examples:

a) 1. Patient B, regularly sees a GP at home, falls ill whilst on holidays interstate. He or she sees a GP interstate who has referred them to a specialist. The patient informs the referring GP/specialist the details of their particular usual GP who works at a group practice.

USUAL GP	
Name	Dr Jeremy BROWN [HPI-I: 8003610200002344]
Organisation	Canberra Medical Centre [HPI-O: 8003620000000233]
Address	2 Scenic Street, Canberra, ACT 2600
Contact	Email: admin@cmc.com.au Phone: 02 3998 8888

b) 2. Patient C, who occasionally visits a GP practice at home, falls ill whilst on holidays. He or she sees another GP who has referred them to a specialist. The patient informs the referring GP/specialist the details of the GP practice that they usually attend. (They usually see any GP at the practice on the day of their appointment.)

USUAL GP	
Name	
Organisation	Canberra Medical Centre [HPI-O: 8003620000000233]
Address	2 Scenic Street, Canberra, ACT 2600
Contact	Email: admin@cmc.com.au Phone: 02 3998 8888

c) 3. Patient E, who typically enjoys good health and has not needed to see a GP regularly, is visiting interstate and falls ill. He or she sees an interstate GP who refers them to a specialist. A related – though alternative – scenario involves the patient electing to see a different GP for a sensitive condition, which they do not want disclosed to their usual GP. They then choose not to identify their usual GP to either the referring GP or the specialist. As no data is entered for this component, the software may be configured to display "None recorded".

USUAL GP
None recorded

2.6.3   Proposed Data model

Data items	DataType	Number of Values Allowed	Notes
Person Name	Person Name data group	0..1	The name of the usual GP, structured using a predefined type consistent with Australian standards of naming (e.g. family name and first name etc), as detailed in NEHTA's Participation Data Specification [PDS2011]. A patient may only nominate a usual GP practice (as an organisation) rather than a specific GP at that practice. In those circumstances, this item may be left empty. When the usual GP nominated is an individual, their name must be provided.
Person Identifier	Unique Identifier	0..Many	The unique individual identifier of the usual GP. A patient may only nominate a usual GP practice (as an organisation) rather than a specific GP at that practice. In those circumstances, this item may be left empty. When the usual GP nominated is an individual, their Person Identifier must be provided, in which case it must include the Healthcare Provider Identifier of the usual GP (HPI-I) and optionally other identifiers (such as provider or prescriber numbers).
Organisation Name	Organisation Name	1	The name of the healthcare provider organisation at which the usual GP practices or the practice which the patient has nominated as their usual GP practice.
Organisation Identifier	Unique Identifier	1	The unique Healthcare Provider Identifier (HPI-O) of the usual GP's practice or the practice which the patient has nominated as their usual GP practice.
Address	Address data group	1..Many	The address of the usual GP, recorded in a structured format consistent with Australian standards of address recording, as detailed in NEHTA's Participation Data Specification [PDS2011].
Communication Details	Electronic Communication Details data group	1..Many	The contact details for the usual GP. The preferred means of contact should be included and should include at least one method of communication. Each Contact Details includes the medium (e.g. telephone), usage (e.g. work) and details.

2.7   Component: Document Recipients

Description: This section is a collection of the recipients of the specialist letter. The recipients of the specialist letter must include the referrer, the usual GP in most cases and other healthcare providers or interested parties. Each recipient must be either an individual healthcare provider, a healthcare organisation, or non-healthcare professional associated with the patient.

2.7.1   Requirements

Data item	Requirement statement	Rationale
Component	Information regarding the recipients of the specialist letter is required for every SL and shall always contain the following mandatory items.	Particularly when there are multiple recipients/healthcare providers, it is very useful for the usual GP to perform their central coordination rile when they can clearly determine who has been given what information.
	A SL shall be allowed to contain multiple recipients.	In complex cases, multiple healthcare providers will be involved with the care of the patient.
Recipient Type	For every recipient of the SL, there shall be a record of the type of recipient, to identify the "primary recipient" or the "secondary recipient".	The current practice is that the primary recipient is the referrer and usual GP and others recipients are secondary.
	A Specialist Letter shall be able to be sent to the same Healthcare provider at multiple locations, if required.	It is common practice to respond (for example) to "Dr Bloggs at his private rooms" with a copy to "Dr Bloggs at his hospital practice".
Organisation Identifier	The SL shall have the provision to record the organisation identifier of an organisation/practice to which a recipient is affiliated.	Allows interoperability. Eliminates ambiguity.
	A value for the Healthcare Provider Identifier of the organisation (HPI-O) shall only be included when the recipient is associated with a healthcare organisation.	A recipient may not be affiliated with an organisation.
Organisation Name	The SL shall have the provision to record the name of an organisation/practice to which a recipient is affiliated.	Healthcare providers may work at different organisations.
	A value for Organisation Name shall only be included when the recipient is associated with an organisation.	A recipient may not be affiliated with an organisation.
Person Identifier	The SL shall have the provision to record the Healthcare Provider Identifier (HPI-I) for a recipient.	Allows interoperability. Eliminates ambiguity. Clinical safety
	A value for Healthcare Provider Identifier (HPI-I) for a recipient shall be included whenever the recipient is an individual healthcare provider.	Allows interoperability; eliminates ambiguity. A copy of a SL may be sent to an organisation (e.g. Community Nursing) or to an individual who is not a healthcare provider (e.g. patient's carer or relative).
	A SL shall have the provision to contain multiple	Such as provider or prescriber numbers.

Data item	Requirement statement	Rationale
	personal identifiers of the recipient, as required.	
Person Name	The SL shall have the provision to record the name of a recipient.	Clarity.
	A value for Person Name shall be included whenever the recipient is an individual. A value for Person Name shall not be included whenever the recipient is not an individual.	Clarity. A copy of a SL may be sent to an organisation (e.g. Community Nursing).
	When recorded, the name of the recipient shall be consistent with Australian Standards of naming.	Allows interoperability; eliminates ambiguity.
Role	The SL shall have the provision to record the Role of a recipient (e.g. 'Referring GP', 'Optometrist' or 'Guardianship Board').	Provides clarity for the recipients of the letter to better understand the role of other recipients of the letter.
	A value for Role shall only be included whenever it is relevant to do so.	A copy of a SL may be sent to an organisation (e.g. Community Nursing) or to an individual who is not a healthcare provider (e.g. patient's carer or relative).
Relationship to Patient	The SL shall have the provision to record the Relationship the recipient has to the patient.	In cases where a letter may be given to a patient's relative or friend, it provides clarity to know how they are related to the patient.
	A value for Relationship to Patient shall only be included whenever the recipient is a non-healthcare provider individual.	The relationship attribute only applies to non-healthcare provider individuals.
Address	The SL shall have the provision to record the recipient's address.	Provides clarity for the recipients of the letter.
	A value for Address shall be included whenever the recipient is a healthcare provider.	It may be necessary to contact or send information to other healthcare providers.
	When the recipient is a non-healthcare provider individual, their address shall be included when it is deemed by the specialist to relevant/appropriate to do so (i.e. optional to include a value).	An address may not be available or appropriate to record for every recipient (e.g. the patient's relative).
	When recorded, recipient's address shall be structured consistent with Australian Standards of address recording.	Allows interoperability; eliminates ambiguity.
	A SL shall be allowed to contain multiple addresses for a recipient.	Caters for the street address as well as the postal address.

Data item	Requirement statement	Rationale
Communication Details	The SL shall have the provision to record a recipient's contact detail.	It may be necessary to contact to other healthcare providers.
	A value for recipient's communication detail shall only be included when it is deemed by the specialist to relevant/appropriate to do so (i.e. optional to include a value).	Some recipients may not have contact details or wish for those details to not be recorded (i.e. relative or friend).
	A SL shall be allowed to contain multiple communication details for a recipient.	This allows relevant telephone numbers (i.e. daytime, after hours, mobile, etc.) and email addresses to be recorded for future reference.
	The contact details record shall include provision for the medium (e.g. telephone, email), usage (e.g. after hours) as well as the actual details.	Allows interoperability; eliminates ambiguity.

2.7.2 Samples & usage[8]

1. A specialist letter is sent to the usual GP of a patient following their referral to a specialist (that is, the usual GP has made the referral). No other copies of the letter are sent.

DOCUMENT RECIPIENTS - Primary					
Name	Organisation	Role	Relationship to Patient	Address	Contact
Dr Jeremy BROWN [HPI-I: 8003610200002344]	Canberra Medical Centre [HPI-O: 8003620000000233]	Referring GP		42 General Street, Canberra, ACT 2600	Email: admin@cmc.com.au Phone: 02 3998 8888

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[8] Health identifier numbers are predominantly for system to system usage and as such they may not necessarily be displayed to end users. The HI numbers are only displayed here to provide additional clarity for these specifications and as such, the reader should not consider this a display requirement.

2. A specialist letter is written for a patient who lives in Sydney, and who has visited a GP in Canberra for a referral to the specialist. A copy of the letter is sent to the patient's husband, their optometrist and the district nursing organisation.

DOCUMENT RECIPIENTS - Primary					
Name	**Organisation**	**Role**	**Relationship to Patient**	**Address**	**Contact**
Dr Jeremy BROWN [HPI-I: 8003610200002344]	Canberra Medical Centre [HPI-O: 8003620000000233]	Referring GP		42 General Street, Canberra, ACT 2600	Email: admin@cmc.com.au Phone: 02 3998 8888
Dr Anna SMITH [HPI-I: 8003610200002355]		Usual GP		5 Harry Road, Oak Park, NSW 3600	Email: asmith@gnet.com.au Phone: 0422 222 222
DOCUMENT RECIPIENTS - Other					
Ms Susan SMITH [HPI-I: 8003610200002566]	Sydney Optometry Centre [HPI-O: 8003620000000555]	Optometrist		111 Harry Rd, Scenic Park, NSW 3600	Email: sue@soc.com.au Phone: 02 3333 7777
	Sydney District Nursing [HPI-O: 8003620000000888]	Home nurse		1 Barry Ave, Scenic Park, NSW 3600	Email: admin@sdn.com.au Phone: 02 3333 0000

2.7.3   Proposed Data model

Data items	DataType	Number of Values Allowed	Notes
Recipient	Group	1..Many	The data group for recording the Recipient(s).
			Multiple recipients are allowed and the following data items apply for each one added.
Recipient Type	Codeable Text	1	The designation of whether the recipient of the document is the "primary recipient" or the "secondary recipient". Each Specialist Letter should have at least one primary recipient. It is recommended that the Primary Recipient is at least the referring GP and the usual GP (unless there are compelling reasons not to). Other healthcare providers or interested parties may be sent a copy of the letter.
Organisation Identifier	Unique Identifier	0..1	The unique organisation identifier of a recipient.
			The recipient may not be associated with an organisation and as such, this item may be left empty. When the recipient is associated with a healthcare organisation, the Healthcare Provider Identifier of the organisation (HPI-O) must be provided.
Organisation Name	Organisation Name	0..1	The name of the recipient's organisation
			The recipient may not be associated with an organisation and as such, this item may be left empty. When the recipient is associated with an organisation, the Organisation Name must be provided.
Person Identifier	Unique Identifier	0..Many	The unique individual identifier of the Document Recipient.
			A specialist letter may be sent to a healthcare organisation, in which case this item may be left empty. Similarly, a copy of a specialist letter may be sent to a patient's relative, in which case a Person Identifier is not applicable.
			Where a named recipient is a healthcare provider, their HPI-I (Healthcare Provider Identifier – Individual) must be provided and optionally other identifiers (such as provider or prescriber numbers).
Person Name	Person Name data group	0..1	The name of the individual recipient, structured using a predefined type consistent with Australian standards of naming (e.g. family name and first name etc), as detailed in NEHTA's Participation Data Specification [PDS2011].
			A copy of a specialist letter may be sent to an organisation, in which case this item may be left empty.
Role	Codeable Text	0..1	The role the recipient is playing in the course of receiving a copy of the specialist letter. For example, 'Referring GP', 'Optometrist' or 'Guardianship Board'.
			A copy of a specialist letter may be sent to a patient's relative, in which case the

Data items		DataType	Number of Values Allowed	Notes
				Role may be left empty.
	Relationship to Patient	Codeable Text	0..1	This describes a non-healthcare recipient's relationship to the patient (for example, husband). Note that this must not be used to identify healthcare relationships - professional or otherwise.
	Address	Address	0..Many	The structured address of the recipient, recorded in a structured format consistent with Australian standards of address recording, as detailed in NEHTA's Participation Data Specification [PDS2011]. An address may not be available or appropriate to record for every recipient, e.g. the patient's relative. However, if the recipient is a healthcare provider the address must be included.
	Communication details	Electronic Communication Details data group	0..Many	The contact details for the document recipient. Communication details may not be available or appropriate to record for every recipient, e.g. the patient's relative. However, if the recipient is a healthcare provider at least one communication detail must be included.

2.8   Component: Response Details

Description: A section that captures clinical information about the response from the specialist following the referral.

2.8.1   Requirements

Data item	Requirement statement	Rationale
Component	Information regarding the Response Details is required for every SL and shall always contain the following mandatory items.	This section conveys important clinical information form the specialist to the GP and other, such as diagnoses, procedures and a clinical narrative of findings etc.
Date Patient Seen	Each SL shall always record the date the patient was seen by the specialist, about which the letter is being written.	This is a Medicare requirement and is also necessary for clinical safety.
	The date the patient was seen shall be structured in a date / time formatted datatype.	Calculations on this date will be required, i.e. validity duration of the referral commences from this date.
Diagnosis and/or Procedures	Each SL shall allow the specialist to record details of diagnoses / procedures.	The nature of the original referral may have been a request for an opinion regarding a particular diagnosis query or a request for a procedure. This section allows that information to be conveyed.
	A SL shall be allowed to contain multiple diagnoses / procedures records.	Multiple records allows for more intelligent data management particularly when these are coded.
	The semantically distinct concepts of diagnoses and procedures shall be combined into one data item.	In the context of primary care referrals, clinicians are generally expect to see these 2 concepts in one chronological list.
	Values for diagnoses and procedures shall be derived from a SNOMED code set with the option for free text.	Allows for more intelligent data mining.
Response Narrative	Each SL shall contain a free text narrative capturing the clinical story / summary of the specialist letter.	The clinical narrative is an important element where a specialist conveys the clinical story to the recipient. It may comprise particular findings, a summarised overview of the situation or a description of significant events etc.

2.8.2   Samples & usage

1.   A table-formatted style of presentation may appear like the following.

RESPONSE DETAILS	
Date Patient Seen	Friday 29 May, 2009.
Diagnosis	- Gastro-oesophageal Reflux Disease - Normal gastroscopy and colonoscopy
Response Narrative	I was delighted to see Mrs. Smith, looking well today following her recent normal gastroscopy and colonoscopy. I reassured her accordingly and discharged her back to your care. I have not arranged to see her again, but will happily do so if required.

2.   Alternatively, the same information may be presented more in the style of a form-letter:

Dear Dr Jones,

I saw your patient on Friday 29 May, 2009.

I was delighted to see Mrs. Smith, looking well today following her recent normal gastroscopy and colonoscopy. I reassured her accordingly and discharged her back to your care. I have not arranged to see her again, but will happily do so if required.

Diagnoses:

Gastro-oesophageal Reflux Disease

Normal gastroscopy and colonoscopy

2.8.3 Proposed Data model

Data items	DataType	Number of Values Allowed	Notes
Date Patient Seen	Date Time	1	The date/time when the patient was seen by the specialist. Validity duration of the referral commences from this date.
Diagnosis and/or Procedures	Codeable Text	1..Many	A description of the problem/diagnosis, or procedures which may or may not be coded.
Response Narrative	Text	1	This free text data element is intended to summarise the response to the referral in a single text field, in narrative form.

2.9   Component: Recommendations

Description: Recommendations by the referee/specialist to a recipient healthcare provider regarding the continuity of care and the ongoing management of the patient. Note that this section excludes recommendations specifically related to medications as this is dealt with in the section 'Medicine List'.

2.9.1   Requirements

Data item	Requirement statement	Rationale
Component	Information regarding recommendations are required for every SL.	Provides clarity regarding what the plan of action is and who is responsible for what.
	Each SL shall either include one (or more) recommendations or a statement as to why none are included.	There may be no recommendations, but even if so, this must still be recorded.
Recommendation To	Every recommendation recorded in the SL shall include to whom the recommendation is intended.	Clinical safety and medico-legal reasons, especially if the letter is sent to more than 1 recipient. There are occurrences where no one has followed up and where everyone has followed up-because of lack of clarity in specialist letter regarding to whom a recommendation is addressed.
	A recommendation can be made to an individual or an organisation.	A recommendation may be made to an organisation such as community nursing, where the exact individual nurse who will attend to the patient is not known by the specialist.
Recommendation Note	Every recommendation recorded in the SL shall include what the actual recommendation is in a free text form.	The specific request of the specialist to ensure that the recipient understands the request.
Recommendation Timeframe	Every recommendation recorded in the SL shall include the timeframe for which it applies.	Clinical and patient safety reasons

2.9.2   Samples & usage[9]

1. The specialist determines that as the specialist letter contains 'for information' type of content, there are no actual recommendations to be made.

RECOMMENDATIONS
No recommendations

2. As a result of the patient consultation, the Cardiologist Dr Ethan Jones has identified a number of recommendations for the usual GP as well as informing the GP that he (the Cardiologist) will review the patient again in 6 months.

RECOMMENDATIONS		
To	**Recommendation**	**Timeframe**
Dr Anna SMITH Usual GP [HPI-I: 8003610200002355]	Monitor diabetic status, renal function and digoxin levels	As you see fit
Dr Anna SMITH Usual GP [HPI-I: 8003610200002355]	Test pacemaker battery	February 2010
Dr Anna SMITH Usual GP [HPI-I: 8003610200002355]	Review cardiac status	July 2010
Dr Ethan JONES Cardiologist [HPI-I: 8003610200002388]	review	six months

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2.9.3　　Proposed Data model

Data items	DataType	Number of Values Allowed	Notes
One (or more) Recommendations must be provided or a reason why none are provided. That is, must have one of the following (a or b), but not both:			
a) Recommendation Exclusion Statement	Coded Text	0..1	Positive assertion that there are no recommendations.
IF no exclusion statement THEN…			
b) Recommendation	Group	0..Many	The data group containing the recommendations. Multiple recommendations are allowed and the following data items apply for each recommendation added.
Recommendation To	Participation	1	The individual or organisation, who will be receiving a copy of the specialist letter, and to which the recommendation is directed and who is responsible for their follow up. The participation data group is detailed in NEHTA's Participation Data Specification v3.0 Version 3.0 — 25 Aug 2010 [PDS2011].
Recommendation Note	Text	1	Details of the recommendation given by the referee. Typically this would include a recommendation regarding when the patient should see the specialist again/discharge from the specialist's care, changes/initiation of treatment or recommended investigations.
Recommendation Timeframe	Text	1	Describes the timeframe for which the recommendation applies. For example, a recommendation for the GP to 'Review cardiac status' that should occur within a timeframe of "3 months" or by a particular date (e.g. "July 2010").

2.10   Component: Medicines List

Description: Recommendation regarding which medicines the patient should continue/commence/cease/alter relevant to and as a consequence of their interaction with the specialist. This is not meant to be a comprehensive medicine list but includes medicines that the specialist decides to make comment about to inform the referring/usual GP.

2.10.1   Requirements

Data item	Requirement statement		Rationale
Component	Information regarding medicines are required for every SL.		Clinical safety
	Each SL shall either include one (or more) medicines or a statement as to why none are included.		Medicines may not be listed in a SL for a variety of reasons – they have not been asked, they are not on any medications, or there have been no changes to medicine list. This provides assurance for the recipient that an absence of medicines is for a specific reason, rather than having just being omitted.
Medicine Status	Every medicine listed in the SL shall include an indication of its corresponding status.		It is important for the recipient to differentiate which medicines may require their attention. For example a medication with a status of "change recommended" will require action by the GP compared to a medicine that has been unchanged.
	The medicine status vales shall be exclusively derived from a predetermined code set, that includes the following options:		This allows software to group like information together and to provide display or validation intelligence (e.g. medications with a status of 'change' must also have a value in the data item 'reason for change').
		"Existing – unchanged"	A medicine that the patient was taking at the prior to the specialist's consultation may be unchanged by the specialist.
		"Existing – changed"	As a result of the consultation, a medicine that was previously taken by the patient may actually be continued but changed by the specialist as it required immediate attention.
		"Existing – change recommended"	As a result of the consultation, the specialist may recommend to the GP that a medicine that was previously taken by the patient be changed. The change may not be urgent or the GP may have an arrangement with the specialist such that all medication changes are to be enacted by the GP as the coordinator of the patient's overall care.
		"Existing - ceased"	As a result of the consultation, a medicine that was previously taken by the patient may actually be ceased by the specialist as it required immediate attention.
		"Existing - cease recommended"	As a result of the consultation, the specialist may recommend to the GP that a medicine that was previously taken by the patient be ceased. The

Data item	Requirement statement	Rationale
		change may not be urgent or the GP may have an arrangement with the specialist such that all medication changes are to be enacted by the GP as the coordinator of the patient's overall care.
	"New – prescribed"	As a result of the consultation, the specialist may prescribe a new medication to be taken by the patient.
	"New – prescription recommended"	As a result of the consultation, the specialist may recommend that the GP prescribe a new medication to be taken by the patient. The addition may not be urgent or the GP may have an arrangement with the specialist such that all medication changes are to be enacted by the GP as the coordinator of the patient's overall care.
Item Description	Every medicine listed in the SL shall include details that fully describe it, including the name of the medicine, strength and dose form, where appropriate.	Allows interoperability. Eliminates ambiguity. Clinical safety.
	Where the medicine can be identified by an Australian Medicines Terminology (AMT) concept, this shall be the AMT ConceptID and Preferred Term.	Interoperability.
	Where the medicine cannot be identified by an Australian Medicines Terminology (AMT) concept, the item description shall be allowed to be carried in free text.	Provides flexibility.
Dose Instructions	There shall be the provision for a medicine record to include the dose instructions, describing how the patient is taking the medicine.	Clinical safety
	A value for Dose Instructions for a given medicine shall only be included when it is deemed by the specialist to relevant/appropriate to do so (i.e. optional to include a value).	The dose instructions may not always be known for all medicines, particularly complementary medicines.
	A SL shall include a Dose Instruction for all non-ceased medications.	Clinical safety.
Reason for Medicine	There shall be the provision for a medicine record to include the reason why the patient is taking the medicine.	It is important for the GP and other recipients to understand the specialist's rationale for (particularly new) medications.
	A SL shall include a Reason for Medicine for all medicines with a status of "New – prescribed" and "New – prescription recommended".	It is important for the GP and other recipients to understand the specialist's rationale for starting (or recommending to start) the patient on a given medication.
	Other than that stated above, a value for Reason for Medicine for a given medicine shall only be included when it is deemed by the specialist to	For medications that are unchanged as a result of the specialist's consultation, it is considered unnecessary for the specialist to add the

Data item	Requirement statement	Rationale
	relevant/appropriate to do so (i.e. optional to include a value).	reason for those medications.
Additional Comments	There shall be the provision for a medicine record to include additional information that may be needed to ensure the continuity of supply, continued proper use, or appropriate medication management.	Clinical safety.
	A value for Additional Comments for a given medicine shall only be included when it is deemed by the specialist to relevant/appropriate to do so (i.e. optional to include a value).	Not always required.
Change Description	There shall be the provision for a medicine record to include description of any change made (or recommended to be made) to a medicine as a result of the consultation.	Clinical safety. Eliminates ambiguity.
	A SL shall include a description of the Change Description for a given medicine, whenever (and only when) the status of that medicine is: - "Existing – changed" - "Existing – change recommended"	Only changed (or recommended to be changed) medicines should logically require a description of that change. Medicines with a status of ceased or cease recommended should have a change description defaulted to 'ceased'.
Reason for Change	There shall be the provision for a medicine record to include the reason that the change was made (or recommended to be made) to a medicine as a result of the consultation.	It is particularly important for any medication changes to be well understood by the recipients of the letter.
	A SL shall include a description of the Reason for Change for a given medicine, whenever (and only when) the status of that medicine is: - "Existing – changed" - "Existing – change recommended" - "Existing - ceased" - "Existing - cease recommended"	Only medicines that have been changed/ceased (or recommended to be changed/ceased) should logically require a reason for that change.

2.10.2   Samples & usage

1.   A patient has been referred by their GP to an ophthalmologist to have a straightforward foreign body removal from their cornea. In this scenario, the medications list would not necessarily appear on the original referral/letter and as such, the patient has not been asked about any medicines.

MEDICINES LIST
Not asked

2.   The patient does not take any medicines.

MEDICINES LIST
None known

3.   The patient has been reviewed by the specialist and they have not made any changes to the patient's medicines.

MEDICINES LIST
No changes to medicine list

4.   The specialist's software lists the patient's medications in the specialist letter including examples for all varieties of medications (Note that the medications listed in the following table are not meant to be from one coherent patient scenario, but simply represent a combined demonstration of each of the status types.). Potentially, recommended items may be displayed with a particular highlight, as in the example below with yellow shading.

MEDICINES LIST						
Status	Medicine	Dose Instructions	Reason for Medicine	Additional Comments	Changes made	Reason for Change
Existing - unchanged	Lasix (frusemide 40 mg) tablet	1 tablet once daily oral	Fluid retention			
Existing - unchanged	Spiriva (tiotropium bromide 18mg per inhalation) inhalant	1 inhalation per day	COPD			
Existing - unchanged	St John's Wort	As directed by packaging				

MEDICINES LIST						
Status	Medicine	Dose Instructions	Reason for Medicine	Additional Comments	Changes made	Reason for Change
Existing - changed	Bicor (bisoprolol 10mg) tablet	Mane oral			Dose increased from 5mg	Diastolic dysfunction
Existing - change recommended	Lasix (frusemide 40 mg) tablet	1 tablet twice daily oral	Fluid retention		Recommend: Decrease dose to 1 tablet once a day	Due to hypotension
Existing - change recommended	Panafcortelone (prednisolone 20mg) tablet	1 tablet once daily oral	Acute gout		Recommend: reduce prednisolone to 10mg for 2 weeks, then stop	No longer required
Existing - ceased	Aldactone (spironolactone 25mg) tablet				Ceased	No longer required
New - prescribed	Cartia (aspirin 100mg) tablet	1 tablet daily oral	Cardiovascular prophylaxis			
New – prescription recommended	Zanidip (lercanidipine hydrochloride 20mg) tablet	1 tablet each day oral	Hypertension			

2.10.3   Proposed Data model

Data items	DataType	Number of Values Allowed	Notes
One (or more) medicines must be provided or a reason why no medicines are listed.			
That is, it must have one of the following (a or b), but not both:			
a) Medicines Exclusion Statement	Coded Text	0..1	This exclusion statement allows for explicit assertions to exclude all medicines; this being the reason why no medications have been listed. This includes, for example, cases where the patient is not known to be taking any medicines, or the patient has not been asked about this information, or that the medicines list is unchanged.
IF no exclusion statement THEN…			
b) Medicine	Group	0..Many	The data group for the medicines that the specialist is describing. Multiple medicines are allowed and the following data items apply for each medicine added.
Status	Coded Text	1	The status of the medicines item at the time of the specialist letter (e.g. 'unchanged', 'changed', 'recommended change', 'ceased', 'corrected' or 'new').
Item Description	Codeable Text	1	The details that fully describe a medicine, including the name of the medicine, strength and dose form, where appropriate.
Dose Instructions	Text	0..1	A description of how a particular product is being taken by the patient. This must include the route, dose quantity, frequency and any additional instructions required to safely describe the appropriate dosage. This should also include the administration schedule. In systems which support the discrete collection of dosage instructions data elements, this

					item only needs to be populated when the discrete dosage items are not.
		Reason for Medicine	Codeable Text	0..1	The clinical justification (e.g. specific therapeutic effect intended) for the use of the medicine. This should be recorded only for new medications.
		Additional Comments	Text	0..1	Any additional information that may be needed to ensure the continuity of supply, continued proper use, or appropriate medication management – e.g. "Patient requires an administration aid", "Dosage to be reviewed in 10 days", "Target INR for warfarin management".
		Changes Description	Codeable Text	0..1	A description of any change made as a result of the consultation.
		Reason for Change	Text	0..1	The justification for the stated change in medication. Required when the medication status is not equal to 'new' or 'unchanged'.

2.11 Component: Newly Identified Allergies and Adverse Reactions

Description: This section includes allergies and adverse reaction to all substances that were identified at the given event. This might include food allergies, bee sting allergies as well as prescription and non-prescription medicines.

These requirements have been developed in collaboration with a specific MMRG Project Working Group and following discussions within Standards Australia.

2.11.1 Requirements

Data item	Requirement statement	Rationale
Component	The SL shall include the provision to include information regarding Allergies and Adverse Reactions should it be relevant to do so.	Information regarding an individual's allergies and adverse reactions is of high clinical safety value.
	Each SL shall have the option to include one (or more) Allergies and Adverse Reactions.	Individuals often have multiple Allergies and Adverse Reactions and allows for future decision support capability.
	When Allergies and Adverse Reactions are added to an SL, the types of information to include are as follows.	
Agent Description	Every allergy and adverse reaction listed in the SL shall contain a description of the causative agent.	Clinical safety.
	Values for the description of the allergy and adverse reaction agent shall be derived from a SNOMED code set with the option for free text.	Allows for the potential for machine processing / decision support.
Reaction Description	There shall be the provision for an allergy and adverse reaction record to include the description of the reaction that was caused by the aforementioned agent.	Unambiguous description of the reaction for clinical safety and allows better informed future management.
	There shall be the provision for more than one reaction to be recorded for a single agent, when appropriate.	An individual may experience multiple adverse reactions to a single agent.
	Preferably, values for the description of the reaction shall be derived from a SNOMED code set (whilst allowing for the option for free text).	Allows for the potential for machine processing / decision support.
	A value for the reaction description shall only be included at the discretion of the SL author, i.e. when it is deemed relevant / appropriate to do so (i.e. optional to include a value).	It may not always be known what the specific reaction is to a given agent. Individuals may report that they have been told that they have a reaction to a given agent but it may not be clear to them what the reaction was specifically. For example, an adult reporting that they were told as a child that they react to a given agent but they cannot recall what happened to them specifically.

2.11.2   Samples & usage

1.   There is no information newly identified about any allergies and adverse reactions.

Individuals may be acutely unwell or otherwise indisposed and unable to provide the relevant health information to their health provider. Further, there may be none that have been newly identified by the specialist. The individual may not actually have any allergies or adverse reactions, this information is not known. In these circumstances it is suggested that the SL would not display this section.

2.   A number of reactions have been newly identified by the specialist; i.e. 2 reactions to penicillin.

NEWLY IDENTIFIED ALLERGIES / ADVERSE REACTIONS	
Agent	Reaction description
Penicillin	Severe urticaria on trunk and legs; Nausea and vomiting

2.11.3   Proposed Data model

Data items	DataType	Number of Values Allowed	Notes
Allergies / Adverse Reaction	Group	0..Many	The data group for the newly identified allergies and adverse reactions for the individual containing the relevant reaction details. Multiple reactions are allowed and the following 2 data items apply for each reaction added.
Agent Description	Codeable Text	1	The agent / substance causing the allergy / adverse reaction experienced by the individual. The agent must always be recorded.
Reaction Description	Codeable Text	0..Many	The signs and/or symptoms experienced or exhibited by the individual as a result of the allergies / adverse reaction to the specific agent/substance.

2.12   Component: Diagnostic Investigations

Description: Describes any diagnostic investigations performed on the patient, relevant to the consultation. This allows the results to be included as an attached report, or as a reference (i.e. link) to where the results are located. Pending results can be indicated using a Result Status of 'pending'.

2.12.1   Requirements

Data item	Requirement statement	Rationale
Component	A specialist letter shall have the provision for attaching diagnostic imaging and results if required.	The inclusion of Diagnostic Investigation results can provide recipients with important supporting information to the specialist's assessment and plans.
	Multiple Diagnostic Investigations shall be allowed to be conveyed in a SL.	Flexibility
Investigation Type	Each investigation included in a SL shall include designation of the 'investigation type'; e.g. 'Pathology', 'Diagnostic Imaging'.	This allows software at either end to group like investigation types together, thereby aiding readability.
Investigation Name	Each investigation included in a SL shall include the corresponding name of that investigation.	Clinical safety. Eliminates ambiguity.
Investigation Date	Each investigation included in a SL shall include the corresponding date on which the investigation was performed.	Clinical safety. Eliminates ambiguity.
Result Status	Each investigation included in a SL shall include the corresponding status of that investigation; e.g. final, pending.	Clinical safety.
Result content	There shall be the provision for Diagnostic Investigations to be associated with a specialist letter either as embedded data or as a URL link to an external repository where the investigation results are located.	Flexibility. Some GPs will want the information included and others may not. Also, since very fast broadband is not likely to be ubiquitous for some time, the option of a link would help reduce payload in the interim (and also storage problems at the receiver's end).

2.12.2   Samples & usage

1.   A number of diagnostic investigations are included within the specialist letter. Due to the size of the images, sending the actual picture file is considered inappropriate and a URL link to the web portal may available to view the image. Conversely, the pathology results are sent within the message and can be opened by the recipient, potentially as a popup window within the application.

DIAGNOSTIC INVESTIGATIONS - Pathology			
Name	Date	Status	Results available at…
UECs	12 Sep 2010	Pending	
FBE	12 Sep 2010	Pending	
LFT	12 Sep 2010	Final	Show[10]
DIAGNOSTIC INVESTIGATIONS – Diagnostic Imaging			
Right knee x-ray	12 Sep 2010	Final	Show[11]
CT head	12 Sep 2010	Interim	Show

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[10] The hyperlink is only provided as an indication of what may be seen by the end user. In the case of data that has been embedded within the message, clicking this hyperlink would invoke the application to display that result by some means within the application (e.g. opening a window).

[11] The hyperlink is only provided as an indication of what may be seen by the end user. The result may not be embedded as data but a URL link included as a reference to an external repository where the investigation result is stored. Clicking this hyperlink would allow the user to navigate to the internet site of the external repository before using the appropriate local application to display that result (e.g. opening a browser window).

2.12.3   Proposed Data model

Data items		DataType	Number of Values Allowed	Notes
Diagnostic Investigation		Group	0..Many	The data group for recording the Diagnostic Investigation(s). Multiple Diagnostic Investigations are allowed and the following data items apply for each one added.
	Investigation Type	Codeable Text	1	The type or category of investigation performed on the patient – e.g. 'Pathology', 'Diagnostic Imaging'. Whilst the type of investigation will be obvious to the majority of clinical readers, the purpose of this data item is to allow the software to sort/group like types together (i.e. all pathology results to be grouped together).
	Investigation Name	Codeable Text	1	The name of the investigation performed on the patient (e.g. 'INR').
	Investigation Date	Date Time	1	The date (or date and time) that the diagnostic investigation was performed (in the case of radiology), or the specimen was taken (in the case of pathology investigations).
	Result Status	Codeable Text	1	The status of the investigation result (e.g. 'pending', 'interim', 'final').
The Diagnostic Investigation can be provided as EITHER / OR the following:				
	Link	Link	0..1	A reference to an external repository where the investigation results are stored. This reference will be presented to the user as a clickable hyperlink which allows them to navigate to the internet site of the external repository using appropriate web services and authentication protocols.
	Data	Encapsulated Data	0..1	The actual content of the investigation report. The report may use one of a variety of formats, including PDF, structured text, or XML using a NEHTA-defined template.

2.13   Component: Attachments

Description: Documents that have been attached to the Specialist Letter (either as a link or as data), because they are relevant to the ongoing care of the patient. For example, ophthalmology eye field scans.

2.13.1   Requirements

Data item	Requirement statement	Rationale
Component	A specialist letter shall have the provision for including attachments, if required.	The inclusion of attachments can provide recipients with important supporting information and background to the specialist's assessment and plans.
	Multiple attachments shall be allowed to be conveyed in a SL.	Flexibility
Document Name	Each attachment included in a SL shall include the corresponding name of that attachment.	Clinical safety. Eliminates ambiguity.
Section Reference	There shall be provision for the SL to include one or more references to a section of the SL to which the attachment is related.	Clarity.
Attachment content	There shall be the provision for an attachment to be associated with a specialist letter either as embedded data or as a URL link to an external repository where the attachment is located.	Flexibility. Some GPs will want the information included and others may not. Also, since very fast broadband is not likely to be ubiquitous for some time, the option of a link would help reduce payload in the interim (and also storage problems at the receiver's end).

2.13.2   Samples & usage

1.   The following attachment has been included within the specialist letter.

ATTACHMENTS		
Name	Section	Results available at...
Ophthalmology eye field scans	Response narrative	Show[12]

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[12] The hyperlink is only provided as an indication of what may be seen by the end user. In the case of data that has been embedded within the message, clicking this hyperlink would invoke the application to display that result by some means within the application (e.g. opening a window). If the result is represented as a URL link as a reference to an external repository where the investigation result is stored, clicking this hyperlink would allow the user to navigate to the internet site of the external repository before using the appropriate local application to display that result (e.g. opening a browser window).

2.13.3   Proposed data model

Data items		DataType	Number of Values Allowed	Notes
Attachment		Group	0..Many	The data group containing the Attachment(s). Multiple attachments are allowed and the following data items apply for each one added.
	Document Name	Text	1	The name of the attached document, to be used when referencing the attachment (e.g. "ophthalmology eye field scans").
	Section Reference	Codeable Text	0..Many	The section in the specialist letter from which the attachment should be referenced (e.g. Pathology, Physical Assessment). This information may be used to organise references to the attachments into appropriate groups.
	An Attachment can be provided as EITHER / OR the following:			
	Link	Link	0..1	A reference to an external repository where the attachment is stored. This reference will be presented to the user as a clickable hyperlink which allows them to navigate to the internet site of the external repository using appropriate web services and authentication protocols.
	Data	Encapsulated Data	0..1	The actual content of the attachment using a variety of formats, including PDF, structured text, image or XML using a NEHTA-defined template.

2.14   Component: Document Control

Description: This section provides information about the specialist letter document and is largely a technical requirement. The data item below is considered the one element of document control that would be relevant for display for end users. There are a number of technical requirements for document control which are not included here as they do not have direct clinical relevance.

2.14.1   Requirements

Data item	Requirement statement	Rationale
DateTime Attested	Each SL shall include the date and time at which the SL was signed off by the specialist.	Clinical safety.

2.14.2   Samples & usage

1.   Each and every specialist letter will display the date & time that it was completed. A table-formatted style of presentation may appear like the following.

SPECIALIST LETTER	
Date Completed	Friday 29 May, 2009.

2.   However, it is likely that the same information may be better presented in the style of a form-letter:

Friday 29 May, 2009

Dear Dr Jones,
I saw your patient on Friday 29 May, 2009.

Thank you for referring Mrs. Smith, a 71 year old female for review of her cardiac status and drop attacks.
It would appear that the major problem is that of diastolic dysfunction. She certainly has very high filling pressures as evidenced by a filling pressure of 32. The LV systolic function remains normal. The valves were morphologically and functionally normal and certainly don't show

2.14.3   Proposed Data model

Data items	DataType	Number of Values Allowed	Notes
DateTime Attested	Date Time	1	The date/time when the Specialist Letter was attested (that is, finalised or signed off) by the document authoriser. This date represents the date at which the specialist has completed the letter, rather than the date on which it was sent. In most cases, these will be equivalent but occasionally where a system may be having distribution errors, the letter may be signed off days before it is actually sent.

3   Specialist Letter Scenario

A typical scenario is as follows:

> A 64 year old female was referred to a Gastroenterologist by her usual GP for opinion regarding her gastrointestinal problems and specifically to consider the procedure of gastroscopy and colonoscopy. She is not taking any medicines and has a history of intermittent diarrhoea, positive occult blood and Gastro-Oesophageal Reflux Disease.

> She is reviewed by the Gastroenterologist who decides that a gastroscopy and colonoscopy are warranted and consequently places her on a waiting list at a nearby hospital. At the end of this consultation, the specialist writes a letter to the GP informing them of his assessment and plans. The letter includes a recommendation that the specialist will perform a gastroscopy and colonoscopy at a date dependant upon waiting lists.

> Following the subsequent gastroscopy and colonoscopy, the Gastroenterologist writes a letter back to the GP informing them of the normal result and that no further gastroenterology input was necessary. The Gastroenterologist recommends that the GP perform a full blood count in six months and that the patient should increase iron in their diet.

Variations on this scenario include:

- A one-off consultation where the specialist informs the GP of their opinion with no further specialist input to follow

- Ongoing specialist consultations where the specialist updates the GP at regular intervals or when there are significant changes

- Ongoing specialist consultations where the specialist updates the GP following each consultation.

In many situations the patient's management may not change as a result of the specialist consultation. In some circumstances however, the specialist may introduce significant changes or make certain recommendations to the GP, which may involve details of specific medications.

In most situations, the referring GP is the patient's usual GP and the specialist's letter is just returned to the GP. In cases of complex multidisciplinary care, the specialist letter may be also sent to other members of the care team and may include recommendations for those other health care providers.

Definitions

This section explains the specialised terminology used in this document.

Shortened Terms

This table lists abbreviations and acronyms in alphabetical order.

Term	Description
AMT	Australian Medicines Terminology
CDA	Clinical Document Architecture
GP	General Practitioner
HI	Health Identifiers
HL7	Health Level 7
HPI-I	Healthcare Provider Identifier of the individual
HPI-O	Healthcare Provider Identifier of the organisation
IHI	Individual Healthcare Identifier
LOINC	Logical Observation Identifiers Names and Codes
NCTIS	NEHTA's National Clinical Terminology and Information Service
SNOMED CT	Systemised Nomenclature of Medicine, Clinical Terminology

Glossary

This table lists specialised terminology in alphabetical order.

Term	Description
Business Architect	A Business Architect is anyone who looks at the way work is being directed and accomplished, and then identifies, designs and oversees the implementation of improvements that are harmonious with the nature and strategy of the organisation. Source: http://www.businessarchitects.org
Development Team	The Developer writes the code for the specifications that the Development leads provide. Source: http://www.developer.com
Endpoint	Where a web service connects to the network. Source: http://www.looselycoupled.com/glossary/endpoint
Interoperability	The ability of software and hardware on multiple machines from multiple vendors to communicate. Source: The Free On-line Dictionary of Computing. Denis Howe. 21 Apr. 2008. From: Dictionary.com - http://dictionary.reference.com/browse/Interoperability
Solutions Architect	The Solutions Architect is typically responsible for matching technologies to the problem being solved. Source: http://www.developer.com
Technical Architect	The technical architect is responsible for transforming the requirements into a set of architecture and design documents that can be used by the rest of the team to actually create the solution. Source: http://www.developer.com

References

At the time of publication, the document versions indicated are valid. However, as all documents listed below are subject to revision, readers are encouraged to use the most recent versions of these documents.

Package Documents

The documents listed below are part of the suite delivered in the Specialist Letter Package.

Specialist Letter Package Documents			
[REF]	Document Name	Publisher	Link
[SL-ES2011]	Specialist Letter Release 1.0 - Executive Summary v1.0	NEHTA 2011	http://nehta.gov.au/e-communications-in-practice/ereferrals/specialist-letter
[SL-RN2011]	Specialist Letter Release 1.0 - Release Notification v1.0		
[SL-BRS2011]	Specialist Letter Release 1.0 - Business Requirements Specification v1.0		
[SL-CIC2011]	Specialist Letter Release 1.0 - Core Information Components v1.0		
[SL-SD2011]	Specialist Letter Release 1.0 - Solution Design v1.0		
[ER-TSS2011]	Specialist Letter Release 1.0 - Technical Service Specification (TBA)		

References

The documents listed below are non-package documents that have been cited in this document.

Reference Documents			
[REF]	Document Name	Publisher	Link
[ERR2011]	Electronic Referrals Release 1.1 package	NEHTA	http://www.nehta.gov.au/e-communications-in-practice/ereferrals; click menu 'e-Referrals Package 1.1'
[PDS2011]	Participation Data Specification Version 3.1	NEHTA 2011	http://www.nehta.gov.au/connecting-australia/terminology-and-information/clinical-information-mi Open menu: Clinical Information Data Specification – Specifications, Context and Requirements

Related Reading

The documents listed below may provide further information about the issues discussed in this document.

Related Documents			
[REF]	Document Name	Publisher	Link

Related Documents			
[NEHTAWEB]	NEHTA Web Site	NEHTA	http://www.nehta.gov.au/